House Bill 6240 includes substantive provisions with respect to the provision of health coverage in the individual and group markets. House Bill 6241 provides conforming amendments to 1980 Public Act 350, the Blue Cross enabling legislation. Some of the subjects addressed by House Bill 6240 include pre-existing condition exclusions, dependent coverage, rescissions, preventive health services and premium rate increases. Although the bill tends to follow the federal health reform provisions, several provisions go beyond what is required under the federal law, thus expanding the burden on health plans:

- **Preventive Services.** Section 3759 requires carriers to provide various preventive services that are recommended by specific bodies, such as the U.S. Preventive Services Task Force. The obligation also requires that carriers waive any cost sharing with respect to those services. While the expansion of preventive health services may be a good policy goal, this provision will unquestionably increase premiums. This provision is inconsistent with federal reform in two major respects:

    - The federal reform's provisions with respect to preventive services are not applicable to "grandfathered plans." (A "grandfathered plan is an insurance policy or certificate of coverage that had enrollment as of March 23, 2010.) The bill does not contain this important exemption.

    - Federal reform establishes a minimum interval between the time when a recommendation is made for a preventive service and the duty of carriers to provide such service (generally one year). The bill does not include this interval, thus creating a state law obligation of carriers to provide coverage immediately once a recommendation is made.

- **Annual Limits.** Section 3755 prohibits "unreasonable" annual limits on benefits. This provision is also inconsistent with federal reform insofar as the prohibition applies to ***individual*** grandfathered plans. Under federal law, only ***group*** grandfathered plans are subject to this prohibition. Thus, the bill expands what is required under federal reform. In addition the prohibition under federal law is not with respect to "unreasonable" annual limits; instead, the prohibition is tied to restrictions as established by the Secretary of Health and Human Services (HHS). In establishing restrictions, HHS is to evaluate the impact on premiums (federal law states the goal of restrictions having a "minimal impact on premiums"). The bill fails to recognize the role of HHS in determining restrictions on annual limits and creates a new, undefined ("unreasonable") standard.

- **Pre-Existing Condition Exclusions**. Section 3763 prohibits pre-existing condition exclusions for children under the age of 19. This provision is also inconsistent with federal reform insofar as the prohibition applies to ***individual*** grandfathered plans. Under federal law, only ***group*** grandfathered plans are subject to this prohibition. Thus, the bill expands what is required under federal reform.

- **Premium Rate Increases**. Section 3765 requires advance notice to OFIR of any premium rate increase before it goes into effect. This section also requires the carrier to provide notice of the rate increase and the justification for the rate increase on the carrier's website. Under federal reform, carriers are required to provide notification/justification of "unreasonable" rate increases (which will be defined by HHS). In addition, HHS is to establish a review process, in conjunction with the states, for reviewing unreasonable premium rate increases. The bill does not contemplate the federal review process, nor does it limit the carrier's reporting and website obligations to "unreasonable" rate increases, thus expanding the obligations of carriers beyond what is required under federal reform.

- **Minimum Medical Loss Ratios/Rebates**. Section 3767 establishes minimum loss ratios and requires rebates to enrollees if a carrier does not meet the minimum standards. The bill uses terms and phrases similar to the federal law which are not defined, such as "clinical services" and "activities that improve health care quality." Under federal law, the definitions of those terms and phrases will be developed by HHS and are to be standardized throughout the nation. The bill does not reflect this concept, thus it is possible that OFIR could interpret these terms and phrases (as a matter of state law) in a manner differently from HHS.